Health Maintenance Organization
Network Access Plan Instructions

Managed Care Section
Division of Market Regulation
Missouri Department of Insurance

The Access Plan

Pursuant to §354.603, RSMo, HMO's licensed in the state of Missouri must file an Access Plan with the Missouri Department of Insurance (MDI). The Access Plan must include the following information. Each of the items and sub-items listed below should be clearly labeled and should be presented in the order we have given, to ensure we give full credit for everything submitted:

1. A description of the health carrier's network (in a format that is described later in these instructions, or a completed affidavit in 20 CSR 400-7.095 Exhibit B);
2. A description of the HMO's procedures for making referrals within and outside its network;
3. A description of the HMO's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;
4. A description of the HMO's method for assessing the health care needs of enrollees and their satisfaction with services;
5. A description of the HMO's method of informing enrollees of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;
6. A description of the HMO's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services (including social services and other community resources) and for ensuring appropriate discharge planning;
7. A description of the HMO's process for enabling enrollees to change primary care physicians;
8. A description of the HMO's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, a reduction in service area or the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees would be notified should any of these events occur, and how enrollees would be transferred to other providers in a timely manner; and
9. Any other information required by the director to determine compliance with the provisions of §RSMo 354.600-354.636:

A. For the **March 1, 2006** filing, the Director requires that all HMOs include their most recent copies of all network provider directories with the access plan, pursuant to §354.603.2(9), RSMo. This includes any sub-directories such as mental health, pharmacy, etc.

B. Information as required by 20 CSR 400-7.095 (2)(A)3 demonstrating the following:

1. Emergency Medical Services – a written triage, treatment and transfer protocol for all ambulance services and hospitals is in place. The protocol shall address post-emergency situations when members have received emergency care from a non-participating provider.
2. Home Health Providers – Home health providers are contracted to serve enrollees in each county where enrollment is reported. A home health provider need not be physically located or headquartered in each county. However, there must be at least one (1) home health provider under contract to serve enrollees in each county if the need arose.
3. Administrative Measures for Timely Access to Appointments are in place for the medical providers listed in Exhibit A based on the following guidelines:
   (a) Routine care, without symptoms – within thirty (30) days from the time the enrollee contacts the provider;
   (b) Routine care, with symptoms – within five (5) business days from the time the enrollee contacts the provider;
   (c) Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by 354.600, RSMo – within twenty-four (24) hours from the time the enrollee contacts the provider,
   (d) Emergency care – a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by 354.600, RSMo;

(e) Obstetrical care – within one (1) week for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency obstetrical care; and
(f) Mental health care – telephone access to a licensed therapist shall be available twenty-four (24) hours per day, seven (7) days per week.

4. A section demonstrating or stating the entire network is available to all enrollees of a managed care plan and describing any network management practices that affect enrollees' access to all participating providers, including employer specific networks.
5. For employer specific networks, a section demonstrating that the group contract holder agreed in writing to the different or reduced network. An employer specific network is subject to the standards in this rule.
6. A listing of the product names used to market the managed care plans.
7. Written policies and procedures to assure that with regard to providers not addressed in Exhibit A of this regulation, access to provider is reasonable. For otherwise covered services, the policies and procedures must show that the HMO will provide out-of-network access at no greater cost to the enrollee than for access to in-network providers if access to in-network providers cannot be assured without unreasonable delay.

C. Information as follows regarding network hospitals which utilize non-network service providers i.e. radiologists, anesthesiologists, pathologists, laboratories (or other hospital-based service providers):

1. Name(s) and address(es) of participating facilities where this occurs.
2. Identify which specific hospital-based service providers are not contracted at that hospital.
3. Method of payment for the non-network services and/or enrollee's financial obligation.
4. Copy of disclosure provided to all enrollees (including POS enrollees) regarding the hospital and the enrollee's possible financial obligation.

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- Annual access plans must be submitted on or before **March 1st** of each year.
- A new access plan must be filed if the HMO experiences a significant change in its network or enrollment or approved service area before the annual filing date.

Additional Instructions for MC+ networks

Pursuant to Attachment 5 of the most recent MC+ contract, MC+ programs are encouraged to reflect any applicable Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Clinics, Family Planning Providers, Local Public Health Agencies or School Based Clinics in the applicable network data file. For example, the location of a Local Health Agency contracted to provide primary care services should be reflected in the provider data file. If the medical professional rendering care at that location is unknown, it is acceptable to put the Local Health Agency's name in either the FRSTNAME or LASTNAME field of the provider data file. Please see pages 8, 10 and 11.

HMOs in the MC+ program are required to include data on participating dental care providers. See page 12 for the required data code for general dental providers. This data fulfills MC+ contract requirements and does not affect any HMO's enrollee access score.

Standards for access to care for HMOs in the MC+ program are more stringent in some cases than those required by the Department of Insurance, for example appointment standards. HMOs in the MC+ program will be evaluated according to the contract with the Division of Medical Services.

General Filing Information

20 CSR 400-7.095 sets forth specific criteria that the MDI will be using to evaluate each HMO's network. The regulation uses distance and wait-time standards set forth for specified medical professionals, facilities and ancillary service providers. These Instructions are intended as guidelines for preparation of the required information.

Filing fees:

Pursuant to §354.495, RSMo, the MDI will collect a filing fee of $20.00 for each Access Plan filed. This fee will be billed through MDI's automated billing system. A TD-1 is **NOT** required.

Where to send the Access Plan(s):

Please mail the completed Access Plan with the required items and diskette(s) on or before **March 1st** to:

Kembra Springs, Managed Care Specialist
Missouri Department of Insurance
Managed Care Section
301 West High Street, Room 530
Jefferson City, MO 65102

The data portion of the Access Plan may be e-mailed. The MDI requests that e-mail submissions be sent to the Managed Care Assistant, Carol Crites, at <Carol.Crites@insurance.mo.gov>. Data files attached to emails should be zipped to ensure they pass MDI's email restrictions.

How to contact the Managed Care Section:

Direct inquiries regarding the Access Plan to Kembra Springs at the above address, or by phone at (573) 526-1371 or via email at <Kembra.Springs@insurance.mo.gov >.

The World Wide Web:

Copies of these instructions can also be obtained on the MDI homepage at:
<http://www.insurance.mo.gov/industry/filings/mc/accessMain.htm>

Reminders:

Networks that contain POS providers: When reporting a network, report only the regular HMO network. Do not include the POS providers and facilities. POS enrollees should continue to be included and reported in the appropriate enrollee file as done in the past.

The 2006 access plans should contain all changes and corrections noted in the 2005 access plans.

The Cover Letter

Please include a cover letter containing the following information:

1. All managed care plans (MCP) offered by the HMO, including each product's name and type.

   NOTE: If separate MCP's have different networks, you must submit a separate set of data files or affidavit for each MCP.

2. A chart indicating the populations served by the HMO and the Missouri counties in which the HMO is currently serving those populations (see example below).

Approved Service Area	Commercial Plan	Medicaid Plan	Medicare Plan	MCHCP Plan
ADAIR	X			X
ANDREW	X	X		X
ATCHISON	X	X	X	
AUDRAIN	X	X	X	X
BARRY	X	X	X	X
BARTON	X		X	

'X' indicates that the HMO serves that population in the corresponding county listed in the first column.

Network Description - Data Submission Guidelines

For each MCP, four distinct data files for each network should be submitted to the MDI for analysis. If the MCP is covered by accreditation, then an affidavit may be submitted instead of data files. Data files that are infected with any form of virus will be destroyed, and must be resubmitted free of viruses. The Managed Care Section uses GeoNetworks to analyze each network. The required files are as follows:

1. The **enrollee file** must contain a count by Zip code of the number of enrollees accessing the network. **DO NOT INCLUDE ADMINISTRATIVE SERVICES ONLY (ASO) MEMBERS IN THE ENROLLEE FILE.** Include only information for members employed or residing in the state of Missouri.
2. The **provider file** must contain information about medical professionals that are available to the members listed in the enrollee file, and with whom the carrier has an agreement or other contractual arrangement. The file must include all subcontracted professionals.
3. The **facility file** must contain information about the facilities that are available to the members listed in the enrollee file, and with whom the carrier has an agreement or other contractual arrangement. The file must include all subcontracted facilities.
4. The **ancillary file** must contain information about the ancillary service providers that are available to the members listed in the enrollee file, and with whom the carrier has an agreement or other contractual arrangement. The file must include all subcontracted ancillary service providers.

All files should contain data as of **January 1st** for the year being reported. Specific formatting guidelines for these files begin on page 7 of these instructions.

Data may be e-mailed to the Managed Care Section, <Carol.Crites@insurance.mo.gov>, or mailed on diskette(s). Data files attached to emails should be zipped to ensure they pass MDI's email restrictions.

General diskette submission guidelines:

Diskettes may be submitted in the following media:

- CD-ROM
- Zip disk
- 3 ½" high density floppy diskette (MS-DOS PC compatible)

Diskettes should be mailed to MDI protected by either a diskette mailer or cardboard. Do not staple the diskette mailer shut. Diskette(s) that are damaged in shipment will not be processed and it will be necessary to resubmit the data.

Diskettes should be clearly labeled with the following information (see Figure 1):

1. Company name;
2. Files on diskette (e.g. Provider.txt);
3. Name and phone number of the person who can answer questions about submitted data;
4. Format of files on diskette (**NOTE:**GeoNetworks will only process data in MSAccess files (*.mdb). MSAccess is preferred. Please contact Kembra Springs at (573) 526-1371 if data is submitted in any other format.)
5. Sequence number (e.g. 1 of 2, 2 of 2)

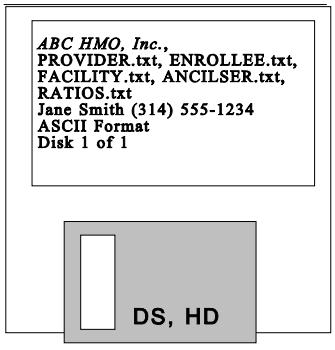

Figure 1. Sample of diskette label. Although MDI would prefer that the labels be typed, labels can be handwritten. However, they must be legible and must include the information indicated above.

I. Enrollee File(s) Instructions

The enrollee file must contain a count by Zip code of the number of enrollees accessing each MCP submitted as of **January 1st**. These files should be submitted in either ASCII (*.txt) or MS Access (*.mdb) formats. File names, field names/column headings, and the required contents of each data file are listed below. The formatting recommendations for submission of ASCII fixed-record length, non-delimited text format are also listed below should the HMO elect to use this format. The number of enrollee files required will depend on what products the HMO offers. **Do not include Administrative Services Only (ASO) members in any file.**

Commercial Plan enrollee file (COMENR.txt or COMENR.mdb)
(including commercial HMO and POS members, combined group and individual, EXCLUDING Medicaid, Medicare, MCHCP and ASO members)
Field 1: ZIPCODE (5-digit Zip code);
Field 2: COUNTCM (Commercial HMO plan enrollee count);
Field 3: NAIC (Reporting HMO's 5-digit NAIC number);

Medicaid Plan enrollee file (MDCDENR.txt or MDCDENR.mdb)
Field 1: ZIPCODE (5-digit Zip code);
Field 2: COUNTMCD (Medicaid plan enrollee count);
Field 3: NAIC (Reporting HMO's 5-digit NAIC number);

Medicare Plan enrollee file (MDCRENR.txt or MDCRENR.mdb)
Field 1: ZIPCODE (5-digit Zip code);
Field 2: COUNTMCR (Medicare plan enrollee count).
Field 3: NAIC (Reporting HMO's 5-digit NAIC number);

MCHCP Plan enrollee file (MCHCPENR.txt or MCHCPENR.mdb)
Field 1: ZIPCODE (5-digit Zip code);
Field 2: COUNTMCH (MCHCP plan enrollee count).
Field 3: NAIC (Reporting HMO's 5-digit NAIC number);

Enrollee File ASCII Parameters: If an ASCII fixed-width file format is used there should be a separate record of fixed-length 18 for each applicable Zip code. All numeric fields should be right justified (left zero filled) and all text fields left justified. Please do not include decimals, commas or carriage control characters in the data file.

Enrollee File ASCII Parameters:

Field Name/Column Heading	Field Length	Field Position	Field Type
ZIPCODE	5	01-05	Text
COUNT*	8	06-13	Numeric
NAIC	5	14-18	Text

*COUNTCM for commercial enrollees, or COUNTMCD for MC+ enrollees, or COUNTMCR for Medicare Advantage enrollees, or COUNTMCH for Missouri Consolidated Health Plan (MCHCP) enrollees

II. Provider File Instructions

Please submit only ONE provider file per MCP. Each provider file must contain medical professionals of the types listed on page 12. This file must contain all subcontracted medical professionals. Failure to include subcontracted medical professionals may cause your network to appear inadequate.

NOTE: Report all medical professionals that would provide services to Missouri enrollees.

NOTE: Report a Primary Care Physician as a Specialist ONLY if he/she is licensed, practicing and contracted to provide that specialty. If a physician serves as both a PCP and a Specialist, place a "1" in both the **PRIMCARE** and **SPCILST** Fields.

NOTE: Addresses should indicate the street, city, state and Zip code where medical professionals practice their specialty. **Do not use PO box numbers! Do not use suite numbers!** GeoNetworks will not process PO boxes or suite numbers. Any medical professional listed with a PO box or a suite number may be excluded from the network analysis. This may cause the HMO's network to appear inadequate. MDI will inform each HMO if their provider file(s) contain address information that cannot be used.

NOTE: If a medical professional practices at multiple locations, please provide a separate record for each address. **Do not put extra practice locations in an "Address 2" field or any variation of supplying that information through additional fields.** Any fields beyond what are required in these instructions are eliminated from the data files prior to analysis. MDI will inform any HMO that is affected if extra address fields were eliminated. MDI does not have the resources to inform HMOs exactly which addresses would be lost if extra address fields are eliminated.

NOTE: License Numbers are those assigned by the Mo. Dept. of Economic Development, Division of Professional Registration. License Numbers are collected on the Standardized Credentialing Form (SCF) for every contracted medical professional. **Do not use ID numbers assigned by the HMO.** Any medical professionals in the provider file that do not have a valid license number may be excluded from the network analysis. MDI will inform any HMO affected if medical professionals were eliminated due to lack of valid license numbers.

NOTE: Some of the medical professional codes begin with zero. **Failure to format SPEC1, SPEC2 and SPEC3 as text fields will result in the loss of leading zeros.** MDI will require the provider file to be resubmitted with the appropriate formatting and intact medical professional codes.

NOTE: For MC+ plans, any of the agencies listed in Attachment 5 of the most recent MC+ contract that are providing primary care or specialty care services should be listed in the provider data file. (An agency or clinic that does not provide the full range of primary care services specified in the MC+ contract cannot be reported as a PCP, but may be reported as any applicable specialty care provider, such as vision care.) If the medical professional rendering care at the applicable location is unknown, it is acceptable to put the applicable agency's name in either the **FRSTNAME** or **LASTNAME** field of the provider data file.

This file is to be prepared based on medical professionals in the applicable network as of **January 1st**.

Provider File ASCII Parameters: If an ASCII fixed-width file format is used, there should be a separate record of fixed-length 143 for each contracted and subcontracted medical professional. **All fields should be left justified text fields**. Please do not include decimals, commas or carriage control characters in the data file.

Field Name/ Column Heading	Field Description	Field Length	Field Position	Field Type
LICNUM	Medical Professional's license number (See p. 8 of the SCF[1])	10	01-10	Text
LASTNAME	Medical Professional's last name	25	11-35	Text
FRSTNAME	Medical Professional's first name	18	36-53	Text
MIDINIT	Medical Professional's middle initial	1	54	Text
PROVADD	Medical Professional's **practice** address **Not a PO Box**	40	55-94	Text
PROVCITY	Medical Professional's **practice** city	20	95-114	Text
PROVST	Medical Professional's **practice** state	2	115-116	Text
ZIPCODE	Medical Professional's **practice** zipcode.	5	117-121	Text
PRIMCARE	Is the Medical Professional a Primary Care Physician? 1=yes 0=no	1	122	Text
SPCILST	Is the Medical Professional a specialist? 1=yes 0=no	1	123	Text
HMOCOMM	Does the Medical Professional see commercial enrollees? 1=yes 0=no	1	124	Text
HMOMDCR	Does the Medical Professional see Medicare enrollees? 1=yes 0=no	1	125	Text
HMOMDCD	Does the Medical Professional see Medicaid enrollees? 1=yes 0=no	1	126	Text
HMOMCHCP	Does the Medical Professional see MCHCP enrollees? 1=yes 0=no	1	127	Text
PRIMEYE	Does Medical Professional's contract include provision of primary medical eye care? 1=yes 0=no	1	128	Text
SPEC1	Medical Professional's most frequently practiced specialty (See p. 7 of the SCF[1] and choose from the list of codes on page 13 of these instructions.)	3	129-131	**Text**[2]
SPEC2	Medical Professional's second most frequently practiced specialty, if any (See p. 7 of the SCF[1] and choose from list of codes on page 13 of these instructions.)	3	132-134	**Text**[2]
SPEC3	Medical Professional's third most frequently practiced specialty, if any (See p. 7 of the SCF[1] and choose from list of codes on page 13 of these instructions.)	3	135-137	**Text**[2]
CLOSPRAC	Is the Medical Professional closed to new patients? 1=yes 0=no (See p.2 #21 of the SCF[1])	1	138	Text
PROVNAIC	Reporting HMO's 5-digit NAIC number	5	139-143	Text

[1]Standardized Credentialing Form for Missouri

[2]Some of the medical professional codes begin with zero. Failure to format Spec1, Spec2 and Spec3 as text fields will result in the loss of leading zeros. MDI will require the provider file to be resubmitted with the appropriate formatting and intact medical professional codes.

III. Facility File Instructions

Please submit only ONE facility file per MCP. Each facility file must contain the facilities listed on page 13, including hospitals, outpatient and inpatient mental health facilities and pharmacies. This file must contain all subcontracted facilities (i.e. third party pharmacy vendors). Failure to report subcontracted facilities may cause your network to appear inadequate.

NOTE: Addresses should indicate the street, city, state and Zip code where each facility is physically located. **Do not use PO box numbers! Do not use suite numbers!** GeoNetworks will not process PO boxes or suite numbers. Any facility listed with a PO box or a suite number may be excluded from the network analysis. This may cause the HMO's network to appear inadequate. MDI will inform each HMO if their facility file(s) contain address information that cannot be used.

NOTE: In order to correctly reflect all services provided by a facility, it may need to be listed more than once in the facility file. For example, a particular hospital could be listed between one and thirteen separate times according to the services it provides. See page 13 for the complete list of all facility codes.

NOTE: For MC+ plans, any of the agencies listed in Attachment 5 of the most recent MC+ contract that are providing mental health or pharmacy services should be listed in the facility data file.

NOTE: It is now permissible to use the NABP# for pharmacies rather than a tax ID number.

This file is to be prepared based on health care facilities in the applicable network as of **January 1st**.

Facility File ASCII Parameters: If an ASCII fixed-width format is used there should be a separate record of fixed-length 234 for each contracted and subcontracted health care facility. All fields should be left justified text fields. Please do not include decimals, commas or carriage control characters in the facility file.

Facility File ASCII Parameters:

Field Name/ Column Heading	Field Description	Field Length	Field Position	Field Type
TAXID	Facility's tax ID number or NABP# for pharmacy	15	01-15	Text
FACTYPE	Type of facility (See list of applicable codes on page 14)	3	16-18	Text
FACNAME	Facility's name	100	19-118	Text
FACSTRT	Facility's street address **Not a PO Box**	80	119-198	Text
FACCITY	Facility's city	20	199-218	Text
FACSTATE	Facility's state	2	219-220	Text
ZIPCODE	Facility's zipcode	5	221-225	Text
FACCOMM	Does the facility see commercial enrollees? 1=yes 0=no	1	226	Text
FACMDCR	Does the facility see Medicare enrollees? 1=yes 0=no	1	227	Text
FACMDCD	Does the facility see Medicaid enrollees? 1=yes 0=no	1	228	Text
FACMCHCP	Does the facility see MCHCP enrollees? 1=yes 0=no	1	229	Text
FACNAIC	Reporting HMO's 5-digit NAIC number	5	230-234	Text

IV. Ancillary Provider File Instructions

Please submit only ONE ancillary file per MCP. Each ancillary file must contain the ancillary service providers listed on page 13, including physical, speech and occupational therapists, and audiologists. This file must contain all subcontracted ancillary service providers. Failure to include subcontracted ancillary service providers may cause your network to appear inadequate.

NOTE: Addresses should indicate the street, city, state and Zip code where each ancillary service provider is physically located. **Do not use PO box numbers! Do not use suite numbers!** GeoNetworks will not process PO boxes or suite numbers. Any ancillary provider listed with a PO box or a suite number may be excluded from the network analysis. This may cause the HMO's network to appear inadequate. MDI will inform each HMO if their ancillary file(s) contained address information that cannot be used.

NOTE: It may be necessary to list an ancillary service provider more than once in order to accurately reflect all services that they may provide. Ancillary service providers may be individuals or facilities. For example, a hospital previously reported in the facility file may provide certain therapy or nursing services, and should be reported in the ancillary file with the appropriate ancillary service code(s).

NOTE: For MC+ plans, any of the agencies listed in Attachment 5 of the most recent MC+ contract that are providing ancillary services should be listed in the ancillary data file.

NOTE: It is no longer necessary to report Home Health Providers in the Ancillary Data File. Home Health Providers are reported in chart form in the written portion of the access plan, per 20 CSR 400-7.095(2)(A)3.A. Please see page 2 of these instructions. Please be aware that this information may be subject to verification by our Market Conduct examiners at any time.

This file is to be prepared based on ancillary service providers in the applicable network as of the **January 1st**.

Ancillary Services File ASCII Parameters: If an ASCII fixed-width format is used there should be a separate record of fixed-length 236 for each contracted and subcontracted ancillary service provider. All fields should be left justified text fields. Do not include decimals, commas or carriage control characters in data file.

Ancillary Services File ASCII Parameters:

Field Name/ Column Heading	Field Description	Field Length	Field Position	Field Type
TAXID	Ancillary service provider's tax ID number	15	01-15	Text
ANCTYPE	Type of ancillary service provider (See list of applicable codes on page 14)	3	16-18	Text
ANCNAME	Ancillary service provider's name	100	19-118	Text
ANCSTRT	Ancillary service provider's street address **Not a PO Box**	80	119-198	Text
ANCCITY	Ancillary service provider's city	20	199-218	Text
ANCSTATE	Ancillary service provider's state	2	219-220	Text
ZIPCODE	Ancillary service provider's zipcode	5	221-225	Text
ANCCOMM	Does the ancillary service provider see commercial enrollees? 1=yes 0=no	1	226	Text
ANCMDCR	Does the ancillary service provider see Medicare enrollees? 1=yes 0=no	1	227	Text
ANCMDCD	Does the ancillary service provider see Medicaid enrollees? 1=yes 0=no	1	228	Text
ANCMCHCP	Does the ancillary service provider see MCHCP enrollees? 1=yes 0=no	1	229	Text
ANCHOME	Does the ancillary service provider offer home-based services to enrollees? 1=yes 0=no	1	230	Text
ANCFACIL	Does the ancillary service provider offer facility-based services to enrollees? 1=yes 0=no	1	231	Text
ANCNAIC	Reporting HMO's 5-digit NAIC number	5	232-236	Text

MEDICAL PROFESSIONAL CODES*

These codes were adapted from the American Medical Association and American Osteopathic Association Specialty Codes List.

Primary Care Providers

General Medicine	087	†Obstetrics	029
Family Medicine	010	†Gynecology	015
Internal Medicine	019	†Obstetrics/Gynecology	030
Pediatrics	038	†Advanced Nurse Practitioners	ANP

†These providers are primary care providers only if the HMO permits this pursuant to the benefits contract and the provider contract. HMO's wanting to use the services of an Advanced Nurse Practitioners as a PCP in their commercial or MCHCP network must request an exception per 20 CSR 400-7.095(3)(A)1.B.(V).

Specialists

Obstetrics/Gynecology	030	Physical Medicine/Rehab	042
Neurology	024	Podiatry	200
Dermatology	006	‡Vision Care/Primary Eye Care	201 or 032

‡ (Ophthalmologists providing primary eye care-report as 032 with 1 in PRIMEYE field. Optometrists providing primary eye care-report as 201 with 1 in PRIMEYE field.)

Medical Subspecialties:

Allergy	002	Orthopedics	202
Cardiology	106	Otolaryngology	094
Endocrinology	009	Pediatric	038
Gastroenterology	011	Pulmonary Disease	048
Hematology/Oncology	110	Rheumatology	053
Infectious Disease	018	Urology	125
Nephrology	023	General Surgery	059
Ophthalmology	032		

Mental Health Providers:

Psychiatrist-Adult/General	043	Psychologists/Other Therapists	PSY
Psychiatrist-Child/Adolescent	044	(Not including psychiatry)	

Chiropractic Care:

Chiropractor	CDO

Dental Care:

*General Dental	GDE

* (Dental Care is required for MC+ networks only.)

Facility Codes

Hospitals

Basic Hospital	HBA
Secondary Hospital	HSE
Level I or Level II Trauma Unit	HT1
Neonatal Intensive Care Unit	HT2
Perinatology Services	HT3
Comprehensive Cancer Services	HT4
Cardiac Catheterization	HT5
Cardiac Surgery	HT6
Pediatric Subspecialty Care	HT7

Pharmacies

Pharmacy	PHA

Mental Health Facilities

Inpatient Mental Health Treatment Facility	IMH
Ambulatory Mental Health Treatment Providers	AMH
Residential Mental Health Treatment Providers	RMH

Ancillary Health Care Service Codes

Physical Therapy	PTA
Occupational Therapy	OTA
Speech Therapy	STA
Audiology	ATA

Affidavit Submission Guidelines

1. The affidavit set forth in Exhibit B of 20 CSR 400-7.095 may be submitted for each managed care plan the HMO operates, in lieu of submission of the data files described in these instructions.
2. If an affidavit is submitted, each managed care plan must fall into at least one of the following categories:
    A. Medicare Advantage
    B. NCQA Accreditation
    C. JCAHO Accreditation
    D. URAC Accreditation
    E. Accreditation by any other nationally recognized managed care accrediting organization which has been received by the department of insurance by October 15 of the year prior to the year the access plan is filed and approved by the department of insurance.
3. In each case, accreditation must be in effect as of March 1, 2006.
4. The affidavit must specify the product name(s) of the managed care plan for which accreditation has been awarded.
5. The form number(s) of the health benefit plan for the managed care plan(s) must be listed on the affidavit.
6. The affidavit must be signed and notarized.
7. Information required by 354.603.2(2) through (9) and by 20 CSR 400-7.095(2)(A)3 must also accompany the affidavit.
8. Please attach a copy of the accreditation certificate to the affidavit, or proof of accreditation identifying the accredited entity.

PLEASE REFER TO THE INSTRUCTIONS, STATUTE & REGULATION FOR ALL REQUIREMENTS.

Requesting Exceptions

1. Quality of Care Exception:
   HMO must submit a request which demonstrates the quality of care to enrollees is enhanced and that it imposes no greater cost to enrollees than they would have incurred if they had access to providers as otherwise required by 20 CSR 400-7.095. If the exception is granted, a score of 90% will then be applied for the provider type in that requested county.

2. Noncompetitive Market Exception for PCP's and Pharmacies:
   HMO must submit a request for consideration of an exception that would double the distance standard for counties that are believed to be lacking available primary care physicians and/or pharmacies that meet the HMO's credentialing standards. The county requested should be listed along with the provider type. A determination will be made by MDI taking into consideration available providers who are practicing in the proximity of the requested county. If no provider of that type is available for contracting, the distance standard set for that county type will be doubled. The recalculated score will then be applied to reflect the access for that county.

3. Noncompetitive Market Exception for other provider types:
   HMO must submit a request for consideration of an exception which would demonstrate that the HMO's nearest contracted provider is practicing at a location which is not more than 25 miles further than the distance to the nearest available provider of that type for that county, or that they have contracted with the nearest available provider for that county. A determination will be made by MDI by taking a measurement to the nearest available provider. If that distance standard is "X", the HMO's nearest contracted provider must be located within "X" plus 25 miles.

   If the nearest contracted provider falls within that distance, an exception will be granted. A score of 90% will then be applied for the provider type in that requested county.

4. Staff or IPA Model Exception:
   HMO must submit documentation that all or substantially all of the health care services provided to enrollees are provided by qualified full-time employees of the HMO and that enrollees have adequate access to the services described in 20 CSR 400-7.095(2)(A)3.A. Documentation must also be provided which demonstrates the contract holder was made aware of the circumstances under which such services were to be provided prior to the decision to contract with the HMO.

5. Use of Physician Extenders in Medically Underserved Areas:
   HMO must request consideration for the addition of physician extenders to meet access obligations in counties that are lacking in available physicians. Along with the request, the HMO must submit a database of the physician extenders that will be available for access. The database should follow the guidelines set forth for providers on pages 8 and 9 of the Access Plan Instructions. The HMO should also submit copies of the contract pages which demonstrate that the provider contract and health benefit plan permit the selection and use of physician extenders. Upon approval of the exception, the database will be merged with the provider file, and the score recalculated for that particular county. The recalculated score will then be applied to reflect access using physician extenders for that county.

PLEASE REFER TO THE INSTRUCTIONS, STATUTE & REGULATION FOR ALL REQUIREMENTS.